Strategic Goal 3

Strategic Goal	Objective	Key Performance Measure
→	→	
Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation	3.1 Provide high-quality, reliable, accessible, timely and efficient health care that maximizes the health and functional status for all enrolled veterans, with special focus on veterans with service-connected conditions, those unable to defray the cost, and those statutorily eligible for care.	Chronic Disease Care Index II
		Prevention Index II
		Percent of patients rating VA health care service as very good or excellent (inpatient and outpatient)
		Average waiting time for new patients seeking primary care clinic appointments
		Average waiting time for next available appointment in specialty clinics
		Increase the aggregate of VA, state and community nursing home and non-institutional long-term care as expressed by average daily census
	3.2 Process pension claims in a timely and accurate manner to provide eligible veterans and their survivors a level of income that raises their standard of living and sense of dignity.	Pension and claims processing measures are combined. These measures will be separated under a new information structure being implemented.
	3.3 Maintain a high level of service to insurance policy holders and their beneficiaries to enhance the financial security of veterans' families.	Average days to process insurance disbursements
	3.4 Ensure that the burial needs of veterans and eligible family members are met.	Percent of veterans served by a burial option within a reasonable distance (75 miles) of their residence
		Percent of respondents who rate the quality of service provided by the national cemeteries as excellent
	3.5 Provide veterans and their families with timely and accurate symbolic expressions of remembrance.	Percent of graves in national cemeteries marked within 60 days of interment

Veterans will have dignity in their lives, especially in time of need, through the provision of health care, pension programs, and life insurance; and the Nation will memorialize them in death for the sacrifices they have made for their

country. To achieve this goal, VA needs to improve the overall health of enrolled veterans, provide a continuum of health care (which includes special populations of veterans), extend pension and life insurance benefits to veterans, meet the burial needs of veterans and eligible family members, and provide veterans and their families with timely and accurate symbolic expressions of remembrance.

The Secretary has mandated that Priority 1 veterans on a waiting list for care, e.g., veterans with service-connected disabilities rated 50 percent of more, or veterans seeking care for their service-connected disability, be moved to the front of the waiting list and receive care first.

The Secretary has suspended enrollment for new Priority 8 veterans for 2003. This decision will be reviewed at the end of the fiscal year to determine if it will continue for FY 2004 or if VA will be able to resume enrollment of Priority 8 veterans. Work is underway with HHS to determine how to give Medicare eligible Priority 8 veterans who cannot enroll in VA's health system access to a "VA+Choice" Medicare plan. This could involve VA contracting with a Medicare+Choice organization, and eligible veterans would be able to use their Medicare benefits to obtain care from VA.

The following table identifies estimates of the total resources devoted to this strategic goal and its associated objectives:

Resources by Objective		
	FY 2004 Obligations	**% of Total VA Resources**
Total VA Resources	$69,743	100%
Strategic Goal 3: Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation.	$19,524	28.0%
Objective		
3.1 Provide high-quality, reliable, accessible, timely and efficient health care that maximizes the health and functional status for all enrolled veterans, with special focus on veterans with service-connected conditions, those unable to defray the cost, and those statutorily eligible for care.	$13,666	19.6%
3.2 Process pension claims in a timely and accurate manner to provide eligible veterans and their survivors a level of income that raises their standard of living and sense of dignity.	$3,539	5.1%
3.3 Maintain a high level of service to insurance policy holders and their beneficiaries to enhance the financial security of veterans' families.	$1,980	2.8%
3.4 Ensure that the burial needs of veterans and eligible family members are met.	$274	0.4%
3.5 Provide veterans and their families with timely and accurate symbolic expressions of remembrance.	$65	0.1%

Provide High-Quality and Timely Health Care

Strategic Goal: Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation.

Objective 3.1: Provide high-quality, reliable, accessible, timely and efficient health care that maximizes the health and functional status for all enrolled veterans, with special focus on veterans with service-connected conditions, those unable to defray the cost, and those statutorily eligible for care.

Performance Goals

- Increase the scores on the Chronic Disease Care Index II (CDCI II) to 79 percent.

Definition: The CDCI II measures how well VA follows nationally recognized clinical guidelines for the treatment and care of patients with one or more of the following high-volume diagnoses: ischemic heart disease, hypertension, chronic obstructive pulmonary disease, diabetes mellitus, major depressive disorder, and tobacco use cessation. The Index is slightly different as new evidence updates the method for testing sensation in the diabetic foot. This change in care delivery will initially impact the overall percent of the Index as this new practice is put into place throughout VHA. Within the Index, each indicator's numerator is the number of patients in the random sample who actually received the intervention they were eligible to receive. The denominator for the calculation is a random sample of the number of patients who are eligible for the intervention. The overall Chronic Disease Index score is comprised of the percent compliance for each indicator summed and divided by the number of individual indicators.

- Increase the scores on the Prevention Index II (PI II) to 82 percent.

Definition: This index charts the outcomes of nine medical interventions that measure how well VA follows national primary-prevention and early-detection recommendations for several diseases or health factors that significantly determine health outcomes: immunizations for both pneumococcal pneumonia and influenza; screening for tobacco and problem alcohol use; cancer screening for colorectal, breast and cervical cancer; screening for hyperlipidemia; and counseling regarding the risks and benefits of prostate cancer screening. Within the Index each indicator's numerator is the number of patients in the random sample who actually received the intervention they were eligible to receive. The denominator for the calculation is a random sample of the number of patients who are eligible for the intervention.

- Maintain at 70 and 71 percent, the percentage of inpatients and outpatients rating VA health care service as "very good" or "excellent."

Definition: The goal to maintain performance at this time is based on changes in methodology. A new and improved patient satisfaction survey was introduced in FY 2002. The initial findings were significantly different with the new survey and it has provided us with only one data point. Therefore, we are limited in out ability to 'project' future performance at this time. This will be adjusted as we gain experience with the new

data collection tool. The numerator consists of a sample of inpatients and a sample of outpatients who, in response to a question on the semi-annual inpatient and the quarterly outpatient surveys, rate their overall quality of care as "very good" or "excellent". The denominator is the total number of inpatients and outpatients in the sample who responded to that question on the survey.

- Reduce the average waiting time for new patients seeking primary care clinic appointments to 30 days.

Definition: Waiting time is the number of days between when the primary care clinic appointment request is made (entered into the computer) and the date for which that the appointment is actually scheduled. The number of days between the appointment request and the appointment schedule date are totaled and divided by all appointments that meet the criteria for "new patient to primary care." New patients are those veterans that have not been seen at a VHA facility within the last two years.

- Reduce the average waiting time for next available appointment in specialty clinics to 30 days.

Definition: Waiting time is the average number of days between when the specialty clinic appointment request is made (entered into the computer) and the date for which that the appointment is actually scheduled. The total number of waiting time days are divided by the number of appointments made. This measure includes all next available requests for appointments in audiology, cardiology, eye care, orthopedics, and urology specialty clinics.

- Increase the aggregate of VA, State and community nursing home, and non-institutional long-term care as expressed by average daily census to 29,981 and 32,694 respectively.

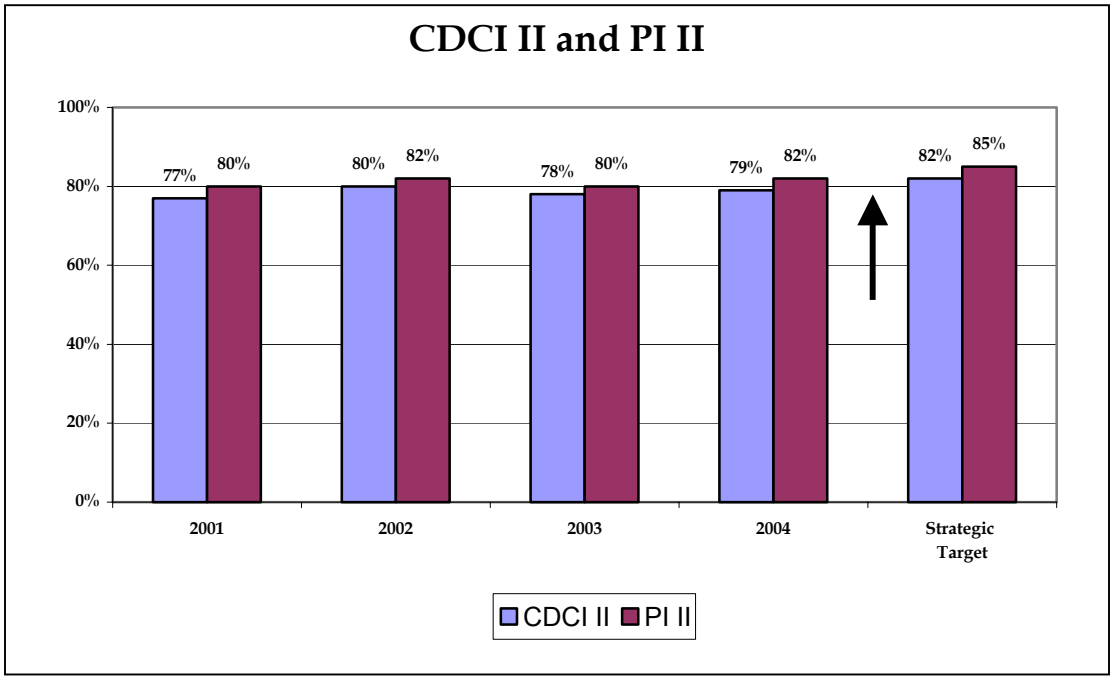
Definition: The number for each subsection is the average daily census of veterans enrolled in institutional care programs (VHA and community nursing homes and State Veteran Homes) and non-institutional programs (Home and Community-Based Care programs, Home-Based Primary Care, Contract Home Health Care, Adult Day Health Care [VA and Contract], and Homemaker/Home Health Aide Services). Average daily census is the total number of patients in the year divided by the number of days in the year.

Current Situation Discussion

VHA's strategy to achieve these goals is to *Put Quality First Until First in Quality* and to *Exceed Patients' Expectations.* To assure the highest quality of care possible, VHA systematically measures and communicates quality of care and patient outcomes. One of two primary quality measures is the Chronic Disease Care Index II, a composite of the evidence and outcomes-based measures for high-prevalence and high-risk diseases. The other is the Prevention Index II, which looks at preventive interventions that can lead to early diagnosis and

prevention of diseases. These both have significant impact on overall health status.

The individual indicators within each Index are based on sound evidence–based medicine, a process that identifies specific processes of care, which in turn impact the overall outcomes for individual patients. For example, in 2002, 86 percent of veterans with chronic lung disease received a pneumoccocal vaccine, one of the targeted interventions in the CDCI II. (The Centers for Disease Control and Prevention reported 50 percent of high-risk Americans received this vaccine in 1999.) VA estimates that this measure has reduced the number of veteran deaths by over 4,000 nationally over the last six years and reduced the number of admissions for pneumonia by 8,000 from 1999 to 2001, which equates to about 9,500 fewer bed days of care. Health care providers have readily accessible information regarding their patients through the use of the Computerized Patient Record System (CPRS). The CPRS can automatically remind the provider at the point of patient contact about the interventions and screening indicators that need to be addressed during the veteran's visit. This technology has led to



an increase in interventions and improved health to the benefit of the veteran.

VA also relies on periodic feedback from veterans, obtained through surveys, as to both the level of their satisfaction with clinical service and other elements of their healthcare experience and utilization. VHA's Performance Analysis Center for Excellence (PACE) conducts a national Survey of Healthcare Experiences of Patients (SHEP) that allows VHA to better understand and meet patient expectations and needs. The satisfaction elements of the SHEP surveys target those dimensions of care that veterans identified as most important to them via

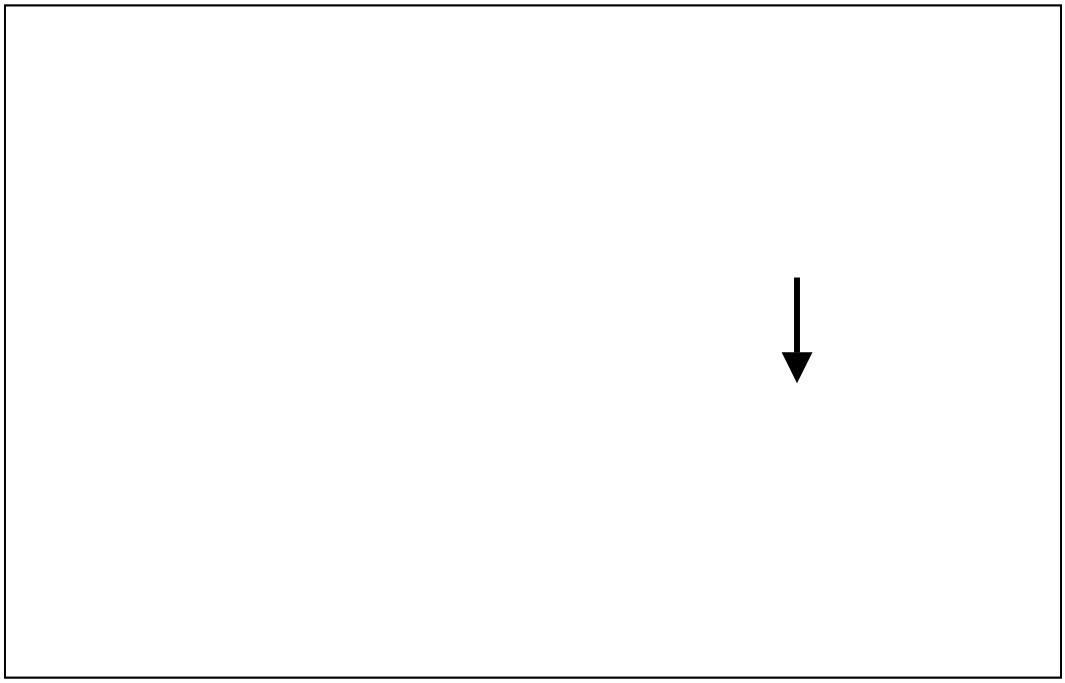
focus group processes. Veteran satisfaction performance is externally compared to other large organizations through use of the National Research Corporation (NRC)/Picker Satisfaction question sets.

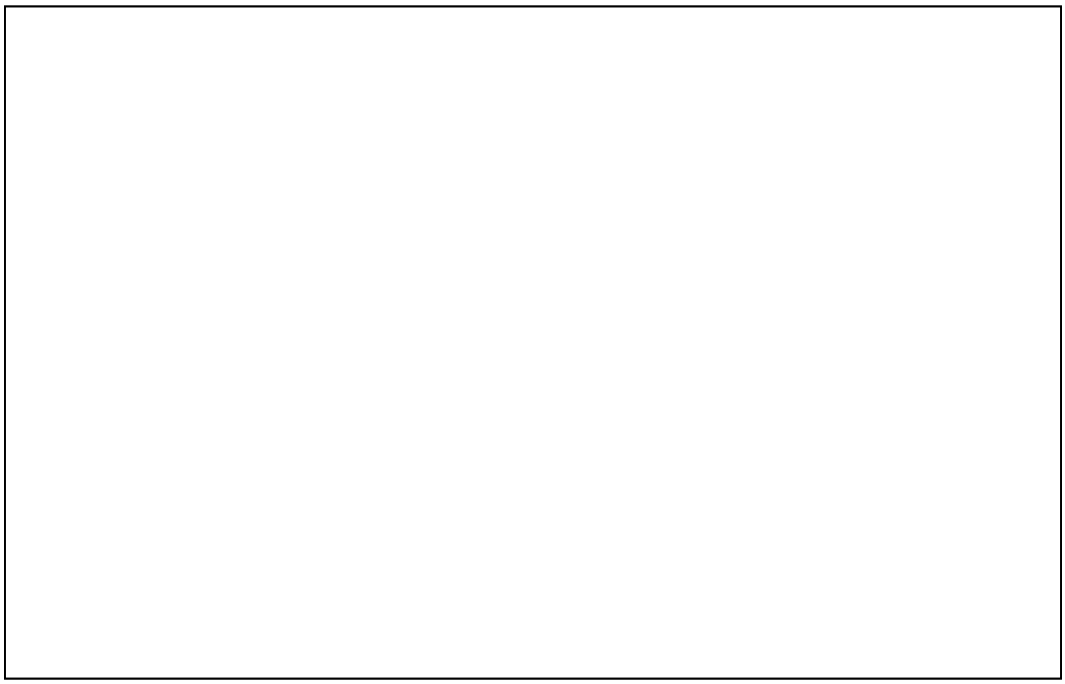
VHA emphasizes health promotion and disease prevention to improve the health of the veteran population. It is a fundamental policy of VA that those veterans who come to us for their health needs will receive the highest quality of health care available.

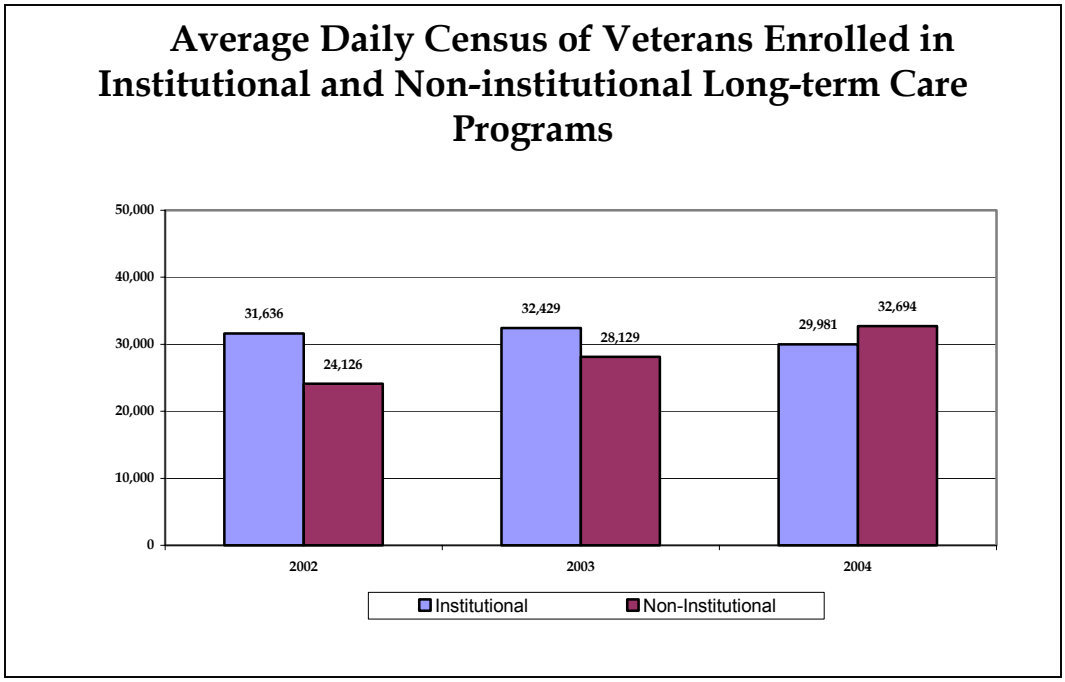
VHA's strategic objective to address the Department's strategic goal and objective is to *Provide Easy Access to Medical Knowledge, Expertise and Care.* VA is working to improve access to clinic appointments and timeliness of service through a number of mechanisms, including the Institute for Healthcare Improvement (IHI) initiative on advance clinic access and a special task force to address those veterans currently waiting to obtain their first appointment. We continue efforts to develop ways to reduce waiting times for appointments in primary care and key specialty clinics nationwide. Past experience in measuring access has led to the development of a number of new data collection options that will provide even more detail on waiting times for new patients and for primary and specialty clinic appointments. As these data collection tools are implemented and tested, VHA will develop additional measures that will allow us to evaluate the outcomes of actions/initiatives taken to reduce waiting times.

VA is also working to expand the use of non-institutional alternatives. Pilots are currently underway to determine the effectiveness of different types of non-

institutional care. Once these pilots are completed and analyzed, VHA will be in position to implement effective programs in non-institutional care.







VA is committed to providing timely access to high quality care for all veterans particularly to our highest priority veterans. The Secretary has mandated that Priority 1 veterans on a waiting list for care, e.g., veterans with service-connected disabilities rated 50 percent or more, be moved to the front of the waiting list and receive care first.

The Veterans' Health Care Eligibility Report Act of 1996 (Public Law 104-262) required VA to enroll veterans for medical care in one of seven distinct priority levels. In general, veterans with service-connected disabilities and low incomes are in the highest priority level for health care while most other veterans are in Priority 8, the lowest priority for care. The following describes how veterans are grouped into priorities:

Priority 1: Veterans with service-connected conditions rated 50 percent or more disabling.

Priority 2: Veterans with service-connected conditions rated 30-40 percent or more disabling.

Priority 3: Veterans who are former prisoners of war, who have service-connected conditions rated 10 to 20 percent disabling, who were discharged from active duty for a disability incurred or aggravated in the line of duty, or veterans awarded special eligibility under 38 U.S.C. 1511.

Priority 4: Veterans who receive aid and attendance or housebound benefits or who have been determined by VA to be catastrophically disabled.

Priority 5: Nonservice-connected veterans and noncompensable service-connected veterans rated zero percent disabled whose annual income and net worth are below the established dollar thresholds.

Priority 6: All other veterans who are not required to make co-payments for care, including World War I and Mexican Border War veterans, veterans solely seeking care for disorders associated with exposure to a toxic substance, radiation or for disorders associated service in the Persian Gulf, or compensable zero percent service-connected veterans.

Priority 7: Zero percent non-compensable service-connected and nonservice-connected veterans with income and/or net worth above the VA Means Test threshold and income below the HUD geographic index.

Priority 8: Zero percent non-compensable service-connected and nonservice-connected veterans who agree to pay specified copayments with income and/or net worth above the VA Means Test threshold and the HUD geographic index.

Each year, the Secretary of Veterans Affairs must determine what priority levels of veterans are eligible to receive care given the level of available resources provided by Congress. Since 1996, the Secretary has declared that all veterans are eligible to receive the full basic benefit package of health care services.

Because of the past and anticipated future increases in the number of Priority 7 veterans who are seeking VA health care, VA cannot continue to provide quality health care to all enrolled veterans (including service-disabled, lower-income veterans, and veterans with special health care needs) within the current direct appropriations. In order to meet the needs of these highest priority veterans, the Secretary has suspended enrollment for new Priority 8 veterans for FY 2003. Work is underway with HHS to determine how to give Medicare eligible Priority 8 veterans who cannot enroll in VA's health care system access to a "VA+Choice" Medicare plan. This could involve VA contracting with a Medicare+Choice organization, and eligible veterans would be able to use their Medicare benefits to obtain care from VA.

Means and Strategies

VA ensures the consistent delivery of health care by implementing standard measures for the provision of evidence-based care by focusing on the use of a Chronic Disease Care Index (CDCI) II. This index is based on the performance of specific processes, provision of certain clinical services, or achievement of certain (proxy) outcomes for which the medical literature has documented evidence of a relationship to good health outcomes. A large percentage of veterans have one or more chronic diseases and the improved management of chronic diseases results in improved health outcomes.

Many of the high prevalence diseases that cause disability or death among Americans could be prevented or delayed through screening, education, and

counseling aimed at risk-factor identification and behavior modification. Through its education programs and screening tests in the Prevention Index II (PI II), VA health care providers urge veterans to become aware of ways in which health can be enhanced, and encourages each person to assume individual responsibility to achieve this goal. The goals of preventive medicine are to maintain health and achieve early detection of disease, thereby easing the burdens associated with cost, suffering, and resource availability in chronic disease management.

VHA will continue to strive to improve patient satisfaction in all areas of service. Surveys are sent to substantial samples of patients who have recently received care in all provider-run (medical doctor, nurse practitioner, physician's assistant) clinics and inpatient settings. The satisfaction elements of the SHEP are in turn compared to comparable care settings of other large healthcare organizations to identify potential areas requiring action. These external comparisons are based on the NRC/Picker comparison pool. VHA is also participating in the Agency for Healthcare Research and Quality-led effort to develop new, standardized satisfaction question sets, which will serve as a proposed national standard.

VHA is working to improve access, convenience, and timeliness of VA health care services. Data on all current waiting times measures includes all patient users except those pending scheduling of their first appointment and, therefore, are showing an incomplete picture. As a result, VA is developing new clinic wait time measures to quantify the wait times of new enrollees. VA is also developing a new survey to assess the experiences of new enrollees in requesting appointments. The data from the new measures, other VHA wait time measures, and the survey will provide more timely and relevant data for decision-making as it relates to the increase in numbers of new enrollees. VA is also recommending the development of a standardized entry process for new enrollees. This process will assist in the automated collection of relevant wait time information at the time that the veteran enrolls in the system. VHA is also optimizing the use of health care information and technology for the benefit of the veteran.

In the face of a declining but aging veteran population, VA will expand access to non-institutional long-term care alternatives and continue to work within VHA and community organizations to provide access to institutional care.

In order for VA to continue to provide high quality care to all enrolled veterans, particularly disabled veterans, those with lower incomes, and veterans with special health care needs, VA must either reduce demand to the level of existing capacity, increase capacity to meet demand, or a combination of both factors. A number of steps will be taken to reduce demand including limiting enrollment and increasing co-payments that would have the effect of reducing

demand. Increasing capacity requires increasing resources either through increased appropriations, achieving cost savings that can be applied to direct medical care, increasing 1st and 3rd party collections, and Medicare subvention or a combination of any or all of these factors.

The proposed policy actions will help narrow the widening gap between demand for services and the capacity to provide those services. They include:

- Stop new enrollment of new Priority 8 veterans as of January 17, 2003.
- For Priority 7 and Priority 8 veterans, effective October 1, 2003, increase pharmacy co-payments from $7 to $15 for a 30-day supply of medication. This will require legislation allowing VA to charge a co-payment greater than the cost of the prescription for some medications. Also, increase outpatient primary care co-payments from $15 to $20.
- Broaden the Millennium Bill language on the long-term care VA capacity requirement to include VA, State and contract average daily census.
- Charge an Enrollment Veterans Health Access fee of $250 to non-service connected Priority 7 and all Priority 8s. Legislation has been proposed in the FY 2004 budget.
- Submit legislation ending the crediting of insurance towards veteran co-payments.
- Achieve management savings in the amount of $316 million in FY 2003 and $950 million in FY 2004 and apply the savings to direct medical care.

VA believes these actions are reasonable and necessary for the VA health care system to survive.

External Factors

Such things as access and waiting times will affect achievement of both the patient satisfaction elements of SHEP and the two Index performance goals.

The success of achieving increased access to long-term care facilities will partially depend on the availability of community resources that can provide long-term care.

Major Management Challenges

Both the General Accounting Office (GAO) and the VA Inspector General (IG) have identified health care quality and patient safety as a major management challenge. The Office of Quality and Performance provides expertise in accreditation programs, Baldrige-based self-assessment and awards, credentialing and privileging, evidence-based clinical guidelines decision support, functional status assessment and analysis, managerial epidemiology, outcomes surveillance and analysis, patient satisfaction assessment and analysis, and performance measurement development and implementation. VHA is

increasingly recognized as a model system for achieving improved, even benchmark-setting outcomes for our patients. Recent findings show that veterans using VA healthcare facilities are receiving comparable and often higher quality care than their private sector counterparts.

The GAO has also identified access as a major management challenge. Access includes how long veterans wait to get an appointment for primary or specialty care after one has been requested. Access also includes how long a veteran with a scheduled appointment waits to be seen. VA has improved access to care by creating hundreds of community-based outpatient clinics (CBOC) in the past several years. VA has developed several new performance measures to further stratify waiting times. VA has entered into short-term contracts with consultants to help reduce backlogs of specialty appointments.

Crosscutting Activities

VA works with DoD regarding prevention, although the actual areas measured may be different. Indicators and identification of at-risk populations are routinely coordinated with the DoD via a process similar to the clinical practice guidelines process.

Data Source and Validation

Data are collected through chart abstraction for the CDCI II and PI II performance measures. The sampling methodology relies upon "established patients," defined as being seen within the last two years and who have been seen at least once in one of eleven main clinics during the current study interval. The External Peer Review Program (EPRP), a contracted, on-site review of clinical records, is the source for both the chronic disease care and prevention index. The EPRP serves as a functional component of VHA's quality management program. The contractor evaluates the validity and reliability of the data using accepted statistical methods. Ongoing inter-rater reliability assessments are performed quarterly for each abstractor in the review process. A random sampling protocol is used to select individual patient charts. Abstractors then review the charts to determine if appropriate data are included. The resulting data are aggregated into appropriate indices. A report is produced quarterly that is available to each VISN.

The source of the patient satisfaction data is VHA's inpatient and ambulatory care respective veteran surveys. The survey consists of a sample of inpatients and a sample of outpatients who, in response to a question on the semi-annual inpatient and the quarterly outpatient surveys, rate their overall quality of care as "very good" or "excellent." The surveys use recognized statistically valid sampling techniques. Regular reports, semi-annual for inpatient and quarterly for outpatient, are available on VISN performance.

The measure that addresses the average new patient waiting time for those patients seeking primary care clinic appointments is calculated using the Veterans Health Information Systems and Technology Architecture (VistA) scheduling software. A new patient is defined as a patient not seen in the prior 24 months at the facility where the appointment is being scheduled and who is in the primary care Decision Support System stop series. The assumption that every new patient wants the next available appointment may overstate waiting times to some degree but not significantly.

The measure that addresses the actual waiting time experienced by all patients needing a next available appointment type in a specialty clinic includes specialties in this calculation that are high volume clinics with histories of long wait times (i.e., audiology, cardiology, eye care, orthopedics, and urology). Although outliers can skew the average, it does more accurately reflect actual individual patient experience. There is a limitation to this indicator in that it is dependent on clerks accurately relaying when the next available appointment is desired. To that end, training has been accomplished and the computer software is set up to encourage correct classification of an appointment into next available or routine. This data is available on a monthly basis.

The long-term care measure is the average daily census of home and community nursing home and home-based care (institutional and non-institutional) beds available for eligible veterans. The data are collected and tracked by VHA's Office of Geriatrics and Extended Care Strategic Healthcare Group. The strategic target figure is based upon the recommendations of the Federal Advisory Committee on Long-Term Care, which called for VA to triple the current proportion of its health care budget for home and community-based care, and to increase the share of Long-Term Care services provided by VA in those VISNs that are below the national average.

Improve Timeliness and Accuracy of Pension Claims Processing

Strategic Goal: Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation.

Objective 3.2: Process pension claims in a timely and accurate manner to provide eligible veterans and their survivors a level of income that raises their standard of living and sense of dignity.

Performance Goals

The Department has adopted a new budget account structure that will allow us to more closely link resources with results and to understand better the full cost of our programs. Previously, compensation and pension programs have been viewed together as part of the overall claims processing activity in VA. But as we move forward with the implementation of this new budget account structure, we expect to refine our performance measures so that they are more specifically linked to the two programs separately.

Current Situation Discussion

Refer to page 32 for a discussion of the timeliness and accuracy of claims processing, which includes both compensation and pension claims.

Maintain High Level of Service to Insurance Policy Holders

Strategic Goal: Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the nation.

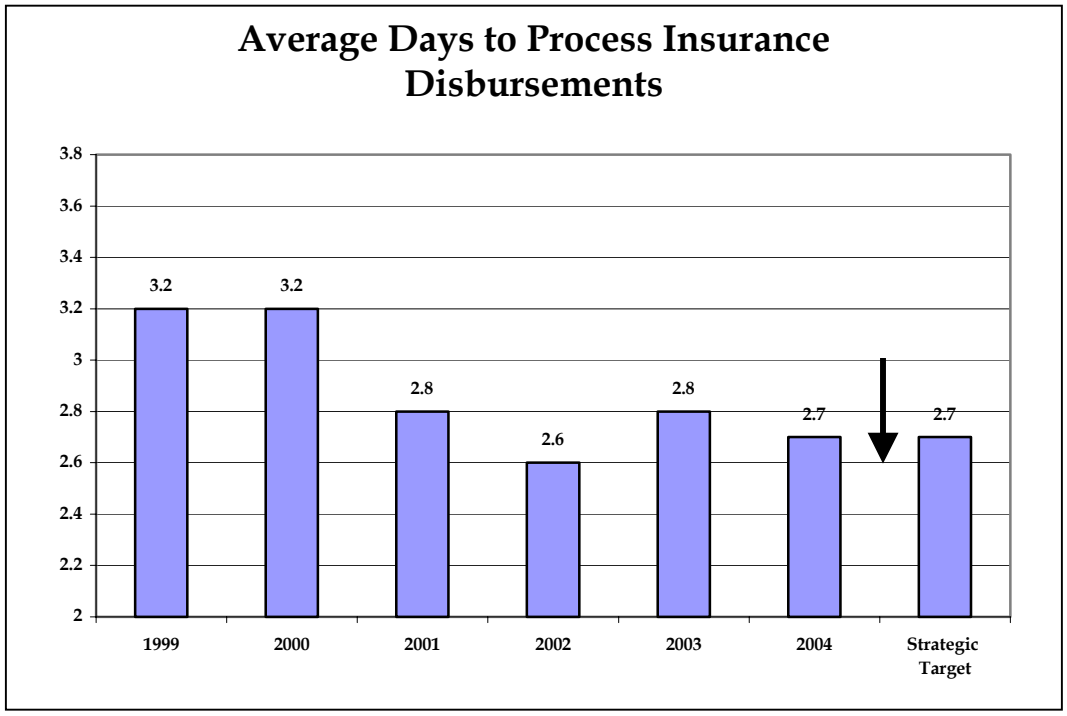
Objective 3.3: Maintain a high level of service to insurance policy holders and their beneficiaries to enhance the financial security of veterans' families.

Performance Goal

- Improve average processing time for insurance disbursements to 2.7 days.

Definition: The weighted composite average processing days for all disbursements, including death claims and applications for policy loans and cash surrenders.

Current Situation Discussion



Our strategic goal is to improve average processing time to 2.7 days, which is below the industry average of 4.9 processing days. Disbursements are considered the most important services provided by the insurance program to veterans and beneficiaries. The indicator for this measure is the weighted composite processing days for all three types of disbursements: death claims, loans, and cash surrenders. Weighted composite average processing days means the volume of end products processed in each category is taken into account in the calculation of the average in order to make it more representative of the group.

We realized a better than expected improvement in average processing days in 2002, due to the installation of the first phase of the paperless processing

system. This initiative will provide Insurance employees with on-line access to policyholder information, allowing them to perform their work in a more efficient manner. We have completed a three-year effort of updating and establishing an electronic image of critical beneficiary information for nearly 1.7 million policyholders. We installed an imaging system that provides electronic storage of insurance records and on-line access to those records. The creation of the large database of imaged insurance records (4.5 million images as of December 2002) allowed for the massive retirement of over two million insurance folders. This has eliminated the need for maintaining and accessing these folders, thereby achieving an estimated savings of $1.2 million annually. The next (and final) phase of the imaging system will come with the installation of the Paperless Processing System. This electronic workflow will be completed in two stages, a pilot test system in one unit of the Insurance Claims Division with full installation to be accomplished in multiple stages. The pilot test system began in July 2002.

Means and Strategies

The insurance program has undertaken various actions to improve the timeliness of disbursements including special post office boxes, improvements in how we process returned mail and the elimination of data processing days. The single most significant factor impacting average processing days for disbursements is the paperless processing initiative, discussed above. The imaging capabilities from the initiative will reduce the time required for processing disbursements and other services.

Crosscutting Activities

Achievement of this goal is not directly dependent on other agencies.

Enhance Insurance Programs

Cooperation from the following stakeholders would possibly be required to implement some of the study's remaining recommendations. These stakeholders include, veterans' service organizations, Congress, and the Office of Management and Budget (OMB).

Major Management Challenges

There are no major management challenges that will affect achievement of this goal.

Data Source and Validation

Processing time begins when the veteran's or beneficiary's application or request is received and ends when the Internal Controls Staff approves the disbursement. Average processing days are a weighted composite for all three types of disbursements, based on the number of end products and timeliness for each category. The average processing days for death claims is multiplied by the

number of death claims processed. The same calculation is done for loans and cash surrenders. The sum of these calculations is divided by the sum of death claims, loans, and cash surrenders processed to arrive at the weighted average processing days for disbursements. Data on processing time are collected and stored through the SQC Program and the DOOR system. The Insurance Service is charged with periodically evaluating the SQC Program to determine if it is being properly implemented. The composite weighted average processing days measure is calculated by the Insurance Service and is subject to periodic reviews.

Ensure Burial Needs are Met

Strategic Goal: Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation.

Objective 3.4: Ensure that the burial needs of veterans and eligible family members are met.

Performance Goals

- Increase the percent of veterans served by a burial option in a national or state veterans cemetery within a reasonable distance (75 miles) of their residence to 81.6 percent in 2004.

Definition: The measure is the number of veterans served by a burial option divided by the total number of veterans, expressed as a percentage. A burial option is defined as a first family member interment option (whether for casketed remains or cremated remains, either in-ground or in columbaria) in a national or state veterans cemetery that is available within 75 miles of the veteran's place of residence.

- Increase the percent of respondents who rate the quality of service provided by the national cemeteries as excellent to 97 percent in 2004.

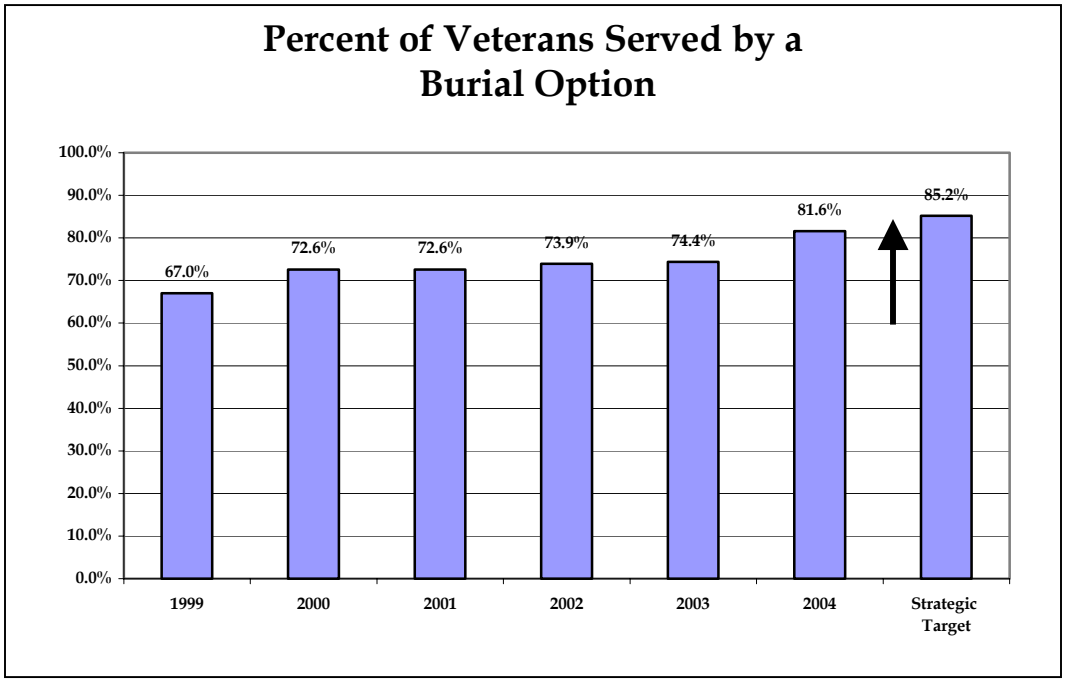
Definition: The measure is the number of survey respondents who agree or strongly agree that the quality of service received from national cemetery staff is excellent divided by the total number of survey respondents, expressed as a percentage.

Current Situation Discussion

The mission of the National Cemetery Administration (NCA) is to "honor veterans with a final resting place and lasting memorials that commemorate their service to our Nation." As veteran deaths continue to increase and new national cemeteries are established throughout the planning time frame, NCA projects increases in the number of annual interments from 89,329 in 2002 to over 109,000 in 2008, an increase of 22 percent.

As annual interments and total gravesites used increase, cemeteries deplete their inventory of space and are no longer able to accept casketed or cremated remains of first family members for interment. This reduces the burial options available to veterans. At the end of 2003, of the 120 existing national cemeteries, 60 will contain available, unassigned gravesites for the burial of both casketed and cremated remains; 24 will accept only cremated remains and remains of family members for interment in the same gravesite as a previously deceased family member; and 36 will perform only interments of family members in the same gravesite as a previously deceased family member. By the year 2008, ten national cemeteries will exhaust their supply of available, unassigned gravesites. Because of overlapping service areas, veterans served by five of these cemeteries will continue to have reasonable access to a burial option at a national or state

veterans cemetery. Overlapping service areas will also reduce the potential number of veterans losing reasonable access to a burial option because of the closings of Beverly, Cypress Hills, New Albany, and Rosenburg National Cemeteries. These cemeteries will continue to accept the remains of family members for interment in the same gravesite as a previously deceased family member.



VA strives to provide high-quality, courteous, and responsive service in all of its contacts with veterans and their families and friends. These contacts include scheduling the committal service, arranging for and conducting interments, and providing information about the cemetery and the location of specific graves.

Means and Strategies

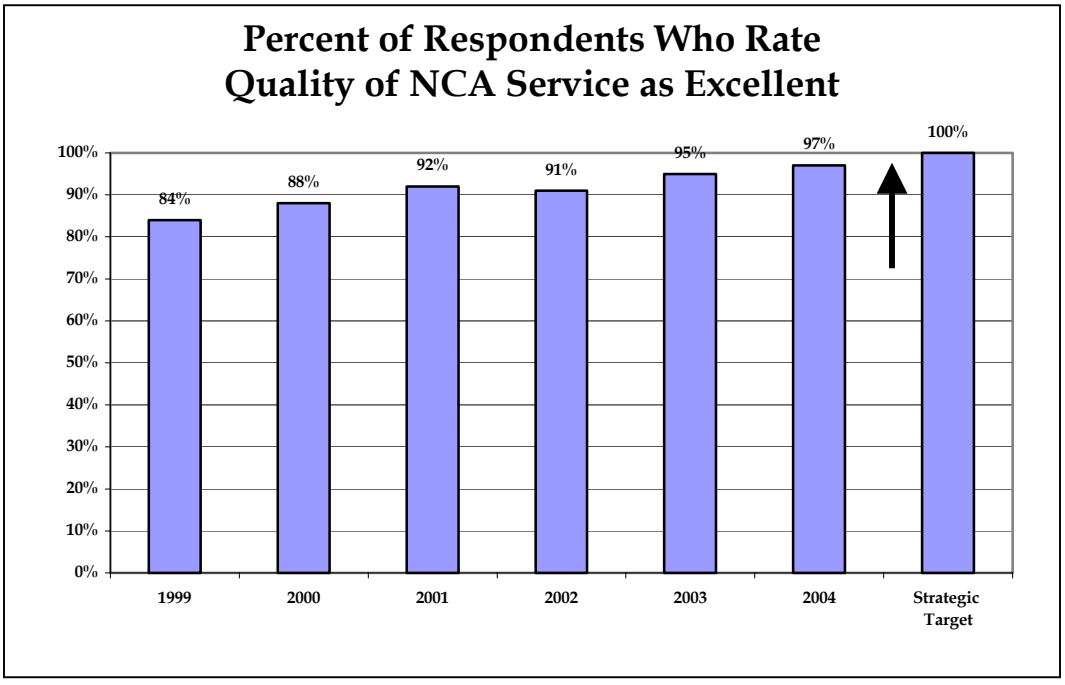
In order to achieve the performance goal of increasing the percentage of veterans served by a burial option in a national or state veterans cemetery within 75 miles of their home, VA needs to increase access by developing additional national cemeteries in under served areas; expanding existing national cemeteries to continue to provide service to meet projected demand, including the development of columbaria and the acquisition of additional land; developing alternative burial options consistent with veterans' expectations; and encouraging states to develop state veterans cemeteries through the State Cemetery Grants Program.

In 2004, interment operations will begin at new national cemeteries in the areas of Atlanta, Georgia; Detroit, Michigan; South Florida; and Pittsburgh,

Pennsylvania, providing reasonable access to a burial option to over 1.6 million veterans. NCA is also planning the development of a new national cemetery to serve more than 314,000 veterans in the area of Sacramento, California.

NCA will expand existing national cemeteries by completing phased development projects in order to make additional gravesites or columbaria available for interments. Phased development in 10-year increments is a part of the routine operation of an open national cemetery. It is the practice of NCA to lay out and sub-divide a cemetery by sections or areas so that it may be developed sequentially as the need approaches. National cemeteries that will close due to depletion of grave space are identified to determine the feasibility of extending the service period of the cemetery by the acquisition of adjacent or contiguous land, or by the construction of columbaria.

NCA will continue to obtain feedback from veterans, their families, and other cemetery visitors to ascertain how they perceive the quality of service provided. NCA's Survey of Satisfaction with National Cemeteries provides a measure of success in delivering service with courtesy, compassion, and respect. NCA will also continue to conduct focus groups to collect data on stakeholder expectations and their perceptions related to the quality of service provided by national cemeteries. The information obtained is analyzed to ensure that NCA addresses those issues most important to its customers. This approach provides data from the customer's perspective, which are critical to developing our objectives and associated measures.



Veterans and their families have indicated that they need to know the interment schedule as soon as possible in order to finalize necessary arrangements. To meet this expectation, NCA strives to schedule committal services at national cemeteries within two hours of the request.

In order to accommodate and better serve its customers, NCA has designated Jefferson Barracks National Cemetery in St. Louis as the primary cemetery to provide weekend scheduling of an interment in a national cemetery for a specific time in the ensuing week.

To increase awareness of benefits and services provided, NCA conducts outreach and education activities for the veteran community and the general public through the use of news releases, articles appearing in veterans service organization publications, public service announcements, and presentations to schools and community organizations.

To further enhance access to information and improve service to veterans and their families, NCA will continue to install kiosk information centers at national and state veterans cemeteries to assist visitors in finding the exact gravesite locations of individuals buried there. In addition to providing the visitor with a cemetery map for use in locating the gravesite, the kiosk information center provides such general information as the cemetery's burial schedule, cemetery history, burial eligibility, and facts about NCA. By the end of 2004, 56 kiosk information centers will be installed at national and state veterans cemeteries.

Crosscutting Activities

VA partners with the states to provide veterans and their eligible family members with burial options through the State Cemetery Grants Program, which provides grants to states for establishing, expanding, or improving state veterans cemeteries, including the acquisition of initial operating equipment. NCA works closely with all State Directors of Veterans Affairs and meets regularly with delegations from states and cities to facilitate the partnership to meet the burial needs of veterans. VA has an active outreach program, and, at the request of state officials, NCA meets with governors and legislators and testifies at state hearings.

NCA is also developing a planning model to encourage and help individual states in establishing state veterans cemeteries through the State Cemetery Grants Program. Two components of the model, an "applicant information kit" and a "standard pre-design briefing," are now in use. Additional modules, to give applicants more information about costs, size and style of buildings, and other development guidelines, will also be included.

NCA and the State of Missouri co-sponsored the first national conference for directors of state veterans cemeteries. The conference, held in the fall of 2001,

provided state cemetery directors with the latest information on best practices in operating Federal veterans cemeteries, and afforded directors the opportunity to share information and build networks that will result in better service to veterans and their families. Plans are underway for another conference to be held in 2003.

NCA works closely with components of DoD and veterans service organizations to provide military funeral honors at national cemeteries. While NCA does not provide military funeral honors, national cemeteries facilitate the provision of funeral honors ceremonies and provide logistical support to funeral honors teams. Veterans and their families have indicated that the provision of military funeral honors for the deceased veteran is important to them.

NCA continues to work with funeral homes and veterans service organizations to find new ways to increase awareness of benefits and services. Funeral directors and members of veterans service organizations participate in regularly conducted focus groups to identify not only what information they need but also the best way to ensure that they receive it.

External Factors

Through the State Cemetery Grants Program, VA has established partnerships with states to provide veterans and their eligible family members with burial options. It is difficult to project future activity for this program because requests for grants are generated from individual states. A state must enact legislation to commit funding to a project that will serve a clearly defined population and require state funds for operations and maintenance in perpetuity.

Veterans and their families may experience feelings of dissatisfaction when their expectations concerning the committal service (including military funeral honors) are not met. Dissatisfaction with services provided by DoD (military funeral honors) or the funeral home can adversely affect the public's perceptions regarding the quality of service provided by the national cemeteries.

Major Management Challenges

There are no major management challenges that will affect achievement of this performance goal.

Data Sources and Validation

Experience and recent historical data show that about 80 percent of those interred in national cemeteries resided within 75 miles of the cemetery at the time of death. From this experience, NCA considers eligible veterans to have reasonable access if a burial option (whether for casketed or cremated remains) is available within 75 miles of the veteran's place of residence. NCA determines the percentage of veterans served by existing national and state veterans cemeteries within a reasonable distance (75 miles) of their residence by analyzing census data on the veteran population. Arlington National Cemetery, operated by the

Department of the Army, and Andrew Johnson National Cemetery and Andersonville National Cemetery, operated by the Department of the Interior, are included in this analysis. Since 2000, actual performance and the target levels of performance have been based on the VetPop2000 model developed by the Office of the Actuary. VetPop2000 is the authoritative VA estimate and projection of the number and characteristics of veterans. It is the first revision of official estimates and projections since 1993. The VetPop2000 methodology resulted in significant changes in the nationwide estimate and projection of the demographic characteristics of the veteran population. These changes affected the individual county veteran populations from which NCA determines the percentage of veterans served. Projected openings of new national or state veterans cemeteries and changes in the service delivery status of existing cemeteries are also considered in determining the veteran population served. (Multiple counts of the same veteran population are avoided in cases of service-area overlap.)

From 1996 to 2000, the source of data used to measure the quality of service provided by national cemeteries was the NCA Visitor Comment Card. Since 2001, an annual nationwide mail survey, Survey of Satisfaction with National Cemeteries, has been NCA's primary source of customer satisfaction data. The survey collects data annually from family members and funeral directors who have recently received services from a national cemetery. To ensure sensitivity to the grieving process, NCA allows a minimum of three months after an interment before including a respondent in the sample population. The measure for quality of service is the percent of respondents who agree or strongly agree that the quality of service received from cemetery staff is excellent. The survey provides statistically valid performance information at the national and Memorial Service Network (MSN) level, and at the cemetery level for cemeteries with at least 400 interments per year. VA headquarters staff oversees the data collection process and provides an annual report at the national level. MSN and cemetery level reports are provided for NCA management's use.

Provide Symbolic Expressions of Remembrance

Strategic Goal: Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation.

Objective 3.5: Provide veterans and their families with timely and accurate symbolic expressions of remembrance.

Performance Goal

Increase the percent of graves in national cemeteries marked within 60 days of interment to 75 percent in 2004.

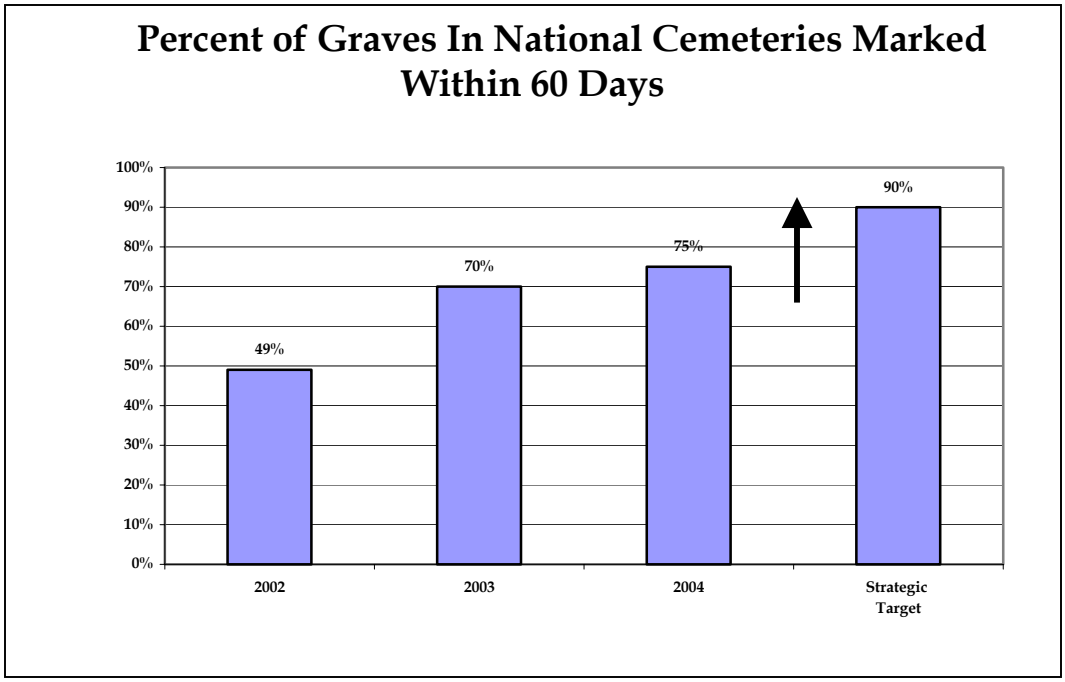
Definition: The measure for timeliness of marking graves in national cemeteries is the number of graves in national cemeteries for which a marker has been set at the grave, or the reverse inscription completed, within 60 days of the interment divided by the number of interments, expressed as a percentage.

Current Situation Discussion

NCA provides headstones and markers for the graves of eligible persons in national, state, other public, and private cemeteries. The amount of time it takes to mark the grave after an interment is extremely important to veterans and their family members. The headstone or marker is a lasting memorial that serves as a focal point not only for present-day survivors but also for future generations. In addition, it may bring a sense of closure to the grieving process to see the grave marked. Delivery of this benefit is not dependent on interment in a national cemetery. In 2002, NCA provided 378,000 applications for headstones and markers for placement in national, state, other public, and private cemeteries. The number of headstone and marker applications processed is expected to be about 379,000 in the year 2004.

NCA developed a data collection instrument to measure the timeliness of marking graves at national cemeteries. A report is distributed to NCA headquarters managers and Memorial Service Network (MSN) directors each month providing monthly and fiscal year-to-date performance for each cemetery and MSN.

To further support this strategic goal, NCA will continue to provide Presidential Memorial Certificates (PMCs) to families of deceased veterans, recognizing and memorializing the veteran's contribution and service to the Nation. A PMC conveys to the family of the veteran the gratitude of the Nation for the veteran's service. To convey this gratitude, it is essential that the certificate be accurately inscribed. NCA issued 289,915 Presidential Memorial Certificates in 2002, and expects this number to increase to 324,400 in 2004.



Means and Strategies

NCA is reengineering business processes, such as ordering and setting headstones and markers, to improve performance. Monthly and fiscal year-to-date tracking reports on timeliness of marking graves can be accessed online by NCA field and headquarters employees. Increasing the visibility and access of this information further reinforces the importance of marking graves in a timely manner.

NCA will continue to improve accuracy and operational processes in order to reduce the number of inaccurate or damaged headstones and markers delivered to the gravesite. Headstones and markers must be replaced when either the Government or the contractor makes errors in the inscription, or if the headstone or marker is damaged during delivery or installation. When headstones and markers must be replaced, it further delays the final portion of the interment process, the placing of the headstone or marker at the gravesite.

NCA will also continue to improve operational efficiencies and reduce costs through its reverse inscription program. In this program, the second inscription is added *in situ* (i.e., at the gravesite) to the currently existing headstone following the death and interment of a subsequent family member. In FY 2002, NCA contracted for over 6,600 reverse inscriptions.

NCA will use, to the maximum extent possible, modern information technology to automate its operational processes. Online ordering using NCA's Automated Monument Application System – Redesign (AMAS-R) and electronic transmission of headstone and marker orders to contractors are improvements

that increase the efficiency of the headstone and marker ordering process. NCA is also increasing its efficiency by encouraging other federal and state veterans cemeteries to place their orders for headstones and markers directly into NCA's AMAS-R monument ordering system. In 2002, 34 other federal and state veterans cemeteries had the capability to order headstones and markers online.

Crosscutting Activities

NCA provides headstones and markers for national cemeteries administered by the Department of the Army, the Department of the Interior (DOI), and the American Battle Monuments Commission. Arlington National Cemetery, which is administered by the Department of the Army, and Andrew Johnson National Cemetery and Andersonville National Cemetery, which are administered by DOI, order headstones and markers directly through NCA's AMAS-R monument ordering system. NCA also contracts for all niche inscriptions at Arlington National Cemetery.

NCA also provides headstones and markers to state veterans cemeteries. State veterans cemeteries are encouraged to place their orders for headstones and markers directly into NCA's AMAS-R monument ordering system. NCA also extends its second inscription program to state veterans cemeteries. In order to participate, state cemeteries must use upright headstones and have the capability to submit requests electronically.

NCA administers the White House program for Presidential Memorial Certificates (PMCs). A PMC is an engraved paper certificate, bearing the President's signature, to honor the memory of honorably discharged deceased veterans. Eligible recipients include the deceased veteran's next of kin and loved ones.

External Factors

Headstones and markers are supplied by outside contractors throughout the United States, whose performance greatly affects the quality of service provided to veterans and their families. The timeliness of delivery of headstones and markers is dependent not only on the performance of the manufacturer but also on the performance of the contracted shipping agent. Extremes in weather, such as periods of excessive rain or snow, or extended periods of freezing temperatures that impact ground conditions, can also cause delays in the delivery and installation of headstones and markers.

Major Management Challenges

There are no major management challenges that will affect achievement of this performance goal.

Data Source and Validation

Workload and timeliness of marking graves data are collected monthly through field station input to the Burial Operations Support System (BOSS) and AMAS-R. The measure for timeliness of marking graves in national cemeteries is the percent of graves in national cemeteries for which a marker has been set at the grave, or the reverse inscription completed, within 60 days of the interment.

The number of headstones and markers provided includes markers ordered by the NCA Centralized Contracting Division (CCD), such as the mass purchase of columbaria niche covers. The total number of PMCs issued, which includes those issued to correct inaccuracies, is reported monthly. Headquarters staff reviews the data for general conformance with previous report periods, and any irregularities are validated through contact with the reporting station.

When headstones or markers are lost, damaged, or incorrectly inscribed, it is important to determine both the cause and the party responsible for the expense of a replacement. NCA developed new codes for ordering replacement headstones or markers and published a users' guide showing definitions for all codes, including the replacement reasons. Use of these new codes has enhanced the BOSS and AMAS-R databases so that these systems produce reliable and accurate data on replacement actions and provide management with an effective tool for improving the overall business process.